PERSPECTIVE

The mental health challenge in Sri Lanka from working within the disaster area

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This perspective is based on our experience in working in the disaster-affected areas of Sri Lanka, as part of the regional task force established by the WPA and the Indo Australasian Psychiatry Association (IAPA), in order to evaluate and plan for the required psychosocial and mental health supports for the affected areas.

The mental health problems in Sri Lanka currently include: a) the mental health problems found in normal times; b) a substantial increase in common mental disorders and other mental health problems due to the adverse effects of the recent disaster; c) the mental health problems due to the adverse effects of conflicts in the North and East of the country. The burden of these problems is not only on the mental health system, but also on the general health system, where most patients tend to seek help for mental health problems, which are typically presented in the form of somatic complaints. The required efforts will not only have to centre on the immediate needs of this population with morbidity, but also include medium- and long-term plans aiming at a) building capacities and b) building and enhancing resilience and coping.

Our current experience with the victims of the tsunami disaster suggests a low prevalence of post-traumatic stress disorder (PTSD) as experienced in similar situations in the West. On the contrary, somatization seems to be common, and the somatic complaints are usually presented to physicians, cardiologists and even surgeons.

Due to the lack of mental health resources and the very limited psychological mindedness of these cultures, psychiatric morbidity usually remains unrecognised and not treated. Compounding this has been the influx of well-intended non-governmental organizations, which are bent on offering trauma-focussed interventions to segments of population affected by the disaster. The interventions most often implemented to reduce traumatic stress are one off psychological debriefing and some benzodiazepines. This approach of promoting PTSD case finding and trauma focussed treatment, in the absence of a system wide public health approach considering pre-existing human and community resources, might be not appropriate.

Another recognisable issue is the place of religion, spirituality and rituals in enhancing resilience, coping and rebuilding through acceptance and finding some meaning even in suffering and loss. It was indeed of significance when a woman who had lost her family and all her possessions told us "I have lost everything I had and now I have only my God". This is at a time when some of us in our safe and comfortable abodes in our cities are debating the existence of a God in the context of this natural disaster. From the interviews of these disaster victims we established that, rather than rocking their faith, this set back has bolstered their belief. If our experience in the affected areas is evenly remotely right, it illustrates the prevalence of faith in the world. Thus, in these resource poor areas, the collaboration of medical and mental health professionals with appropriate traditional resources, such as faith heelers, pastoral care, clergy and similar, is seen as an important and necessary engagement and an opportunity in terms of care, provision of meaning and general community support.

We believe that management of this disaster will need to be tailored to each of the regions, that have varying needs, resources and cultures. To address this situation of massive needs and very limited professional resources, many innovative approaches will have to be considered. These will include training alternative professionals and use of community resources such as teachers, appropriate faith healers, clergy and volunteers to empower the population. In the promotion of culturally acceptable forms of coping, some strategies and interventions that have been used successfully in other disaster situations may be considered. One example, borrowed from the Education for Peace program of Lebanon, is the technique not to focus on the child's emotional wounds but to re-establish a sense of normality by providing education and educational materials and fostering an environment in which wounds will heal naturally. As there is evidence of a high correlation between mother's distress and that of the child, the whole family should become the focus of effective support, by increasing communication among family members, strengthening family rituals and sharing of emotions.

Traditional methods of support and community solidarity should be encouraged. With the massive loss of life and large-scale displacement that has taken place, the rebuilding of community support is in reality a way of promoting mental health of the population. The media can have an important positive influence in spreading the mental health promotion message to the general population.

Finally, in all the efforts to help, there is a temptation to implement short-term measures to alleviate suffering. This, however, must be accompanied by a long-term plan to rebuild essential mental health services at the primary, secondary and tertiary levels. This will mean not only empowerment of the people, but preparing the population for future disasters and emergencies.